MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Panel Summary
Meeting of February 3, 2004
Sacramento, California

Panel Members Present:	Jack Campana, Michael Kirkpatrick, Elizabeth Stanley-Salazar, Heather Bonser-Bishop, Ellen Beck, M.D., Martha Jazo-Bajet, RN, MPH, Jose Carvajal, Gerald Kozai, Ronald Diluigi, Iantha Thompson, Margaret Jacobs
Staff Present:	Joyce Iseri, Irma Michel, Tom Williams, Lorraine Brown, Janette Lopez, Judy Torres, Mary Watanabe, Laura Gutierrez
Board Members Present:	Virginia Gotlieb, M.P.H.

Introductions

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chair, opened the meeting by introducing himself and asking the Panel members, staff and the audience to introduce themselves.

Welcome New Panel Members and Administer Oath of Office

Mr. Campana stated that six members were appointed to the panel, four of which had been on the panel and were re-appointed. Irma Michel, Deputy Director of Eligibility, Enrollment and Marketing for MRMIB administered the oath of office to the following five Panel members who were present at this meeting:

- Martha Jazo-Bajet, RN, MPH, the Health Plan Representative;
- Michael Kirkpatrick, the Non-Profit Clinic Representative;
- Ronald Diluigi, the Business Representative;
- Elizabeth Stanley-Salazar, the Substance Abuse Provider Representative; and
- Iantha Thompson, the County Public Health Representative.

Review and Approval of the July 29, 2003 HFP Advisory Panel Meeting Summary

Panel member Ellen Beck, M.D., requested that an amendment be made to the summary to reflect that she had also recommended that HFP consider instituting a benefit for orthodontia. The Panel approved the July 29, 2003 HFP Advisory Panel Meeting Summary with Dr. Beck's amendment.

Mr. Campana stated that at the last meeting, the Panel had agreed to send a letter to Governor Davis regarding the possible reduction of staff, but had decided to wait due to the election of Governor Schwarzenegger. He added that there was a 10% reduction in

staff, but several staff had left voluntarily, so there were no layoffs. Joyce Iseri, Chief Deputy Director for MRMIB, stated that MRMIB had lost 10.5 positions, despite carrying an increased workload.

Budget Update

Tom Williams, Deputy Director of Administration for MRMIB, reviewed the highlights of the 2004-05 Governor's Budget. He stated that some of the items would need further development as part of the May Revision, including the proposed enrollment cap on HFP. The enrollment cap would take legislative action before it could be implemented.

Mr. Campana asked if there was a projection of how many children would be on the waiting list after six to eight months. Mr. Williams responded that based on the November enrollment estimate and the current rate of disenrollment, it is estimated that:

- In January 2004 there would be 9,000 children on the waiting list with an average wait of one month,
- By June 30, 2004 there would be 56,000 children on the waiting list with an average wait of four months,
- By June 30, 2005 there would be 159,000 children on the waiting list with an average wait of eight months, and
- Eighteen months out, approximately 8,500 children would be added to the waiting list each month.

Ms. Iseri added that other states that have implemented an enrollment cap, found that there was a higher rate of retention, so these numbers could be higher.

Panel member Jose Carvajal asked if families would need to reapply once they were eligible for the program and no longer on the waiting list. Ms. Michel responded that the details still need to be defined because the enrollment cap has not been implemented.

Panel member Elizabeth Stanley-Salazar asked what percentage of the applications received at Single Point of Entry (SPE) were Medi-Cal eligible. Ms. Michel responded that 35% are forwarded to Medi-Cal and 12% are forwarded to both HFP and Medi-Cal, so approximately 47% are forwarded to Medi-Cal as of December 2003.

Panel member Ronald Diluigi asked if the worse case scenario would be 8,500 children added to the waiting list each month. Mr. Williams responded that it is the current estimate, but in talking to other states that have implemented a cap, families tend to do a better job at Annual Eligibility Review (AER) and in making payments resulting in a slow down in disenrollment. If that is also true in California, there would be an increased number on the waiting list each month and in the time it takes to be enrolled in the program. Ms. Stanley-Salazar stated that there are still approximately 300,000 children that we have not reached at all.

Panel member Heather Bonser-Bishop stated that in her outreach, they will move to tracking retention. She asked if there would be a way to have a tiered list base on need and a way for those who really needed care to move up the waiting list. Ms. Iseri

responded that other states who have implemented a cap recommended that the list not be set up by priority. Ms. Michel responded that even children who lose Medi-Cal coverage can't automatically come into HFP. She added that setting priority gets into the medical area and there are no doctors on staff to determine necessity of care nor are there questions on the application.

Panel member Iantha Thompson stated that the cap would be statewide, not by area, and there could be areas where a lot of the children are on the waiting list and have poor access to care. Ms. Stanley-Salazar stated that in the last two years she has read a lot about the problems other states have had with caps. Ms. Iseri responded that there are six states with enrollment caps. There was a seventh state, but after the experience of other states, they decided not to do it because it was so unpopular.

Mr. Campana stated that the state would be turning away federal dollars for 2/3 of the cost when children with chronic diseases need coverage. He added that this should be a political hot potato that the Panel should bring forward.

Panel member Martha Jazo-Bajet asked if the Board had thought about how it will educate subscribers on the implementation of the cap. Ms. Michel stated that there is no funding for media or outreach, so the Board would need to rely on its business partners and network to spread the word. Ms. Jazo-Bajet stated that the quicker the message goes out, the better chance counties have of retaining children in the program.

Mr. Diluigi stated that there needs to be significant budget cuts, but placing a cap on enrollment doesn't make sense from a financial and service perspective. Forfeiting significant federal dollars doesn't make sense. He asked if there were estimates on how much federal funding would be lost. Mr. Williams responded that based on December's estimates, the estimated loss in federal funds for the budget year would be $55 million and an estimated savings to the state of $32 million.

Ms. Bonser-Bishop stated that children who are on the waiting list will turn to community health centers that will put them on the Children's Health and Disability Prevention (CHDP). She asked how this will work and if they will still be able to enroll in CHDP. Ms. Michel responded that CHDP children will still get two months of pre-enrollment coverage, but if they are HFP eligible, they will go on the waiting list after that and their pre-enrollment status will be terminated.

Dr. Beck suggested strengthening the disenrollment letter to convey the importance of staying in the program. Ms. Michel stated that the phone call scripts and letters will be changed to educate subscribers on the consequences of disenrollment. Dr. Beck expressed her concern for the children that are seriously ill and those that would be dropped from Medi-Cal. She suggested raising public awareness of these types of cases where children with serious illnesses would lose coverage. Mr. Campana stated that this is something the Panel can do by making a recommendation to the Board about the Panel's concerns regarding the most serious cases and the impact it will have.

Panel member Margaret Jacobs suggested that families be given a special card that would allow them to get emergency services, such as immunizations and treatment of chronic conditions, while they are on the waiting list. She added that in Medi-Cal, children are disenrolled at 6 years of age and suggested that a Department of Health Services (DHS) worker notify the family and tell them they need to get on the HFP waiting list. Ms. Michel responded that once a child is no longer eligible for Medi-Cal, their application is forwarded from the counties to HFP.

Panel member Gerald Kozai stated that from a provider's perspective, in the past, children always had some form of safety net, whether it was California Children's Services (CCS), HFP or CHDP. There is already a statewide crisis with emergency rooms that are full, a lack of physicians and a health care system on the brink of collapse, and now that safety net will be gone. He added that the message needs to go out that before all of these changes, every child had access to some form of health insurance, but now that will be gone.

Mr. Campana asked what the cost of maintaining the list would be and who would maintain it. Mr. Williams responded that the Board budgeted $1 million for revising materials, mailing notices and maintaining the waiting list. He added that any savings in the current year are offset by administrative costs.

Mr. Williams reviewed the Legal Immigrant Block Grant Proposal. Dr. Beck asked if the proposal would lead to reduced benefits and services that can be provided in HFP. Ms. Michel responded that legal immigrants are paid for solely by the state. We do not know what type of benefits legal immigrants would receive through Block Grant Proposal for the county. Mr. Williams added that the details would be worked out in the May Revision, but it is estimated that this would affect 21,000 children or about 3% of the total HFP enrollment.

Dr. Beck asked if the economic status of these children is known. Mr. Williams responded that they are spread out, but there are fewer infants at 200-250% FPL.

Mr. Williams reviewed the Two-Tiered Benefit Proposal. Ms. Stanley-Salazar asked how much revenue would be generated by a two-tiered system. Mr. Williams responded that the biggest savings comes from selecting the reduced benefit package, not increased premiums.

Ms. Bonser-Bishop stated that as a subscriber at 250% FPL, her premiums would increase from $108 to $270, but it never occurred to her to reduce her benefits because the dental benefit is so important.

Mr. Williams reviewed the proposed budget changes in Medi-Cal that effect HFP. He added that a full copy of the governor's budget is available on the Department of Finance (DOF) website at www.dof.ca.gov .

Ms. Stanley-Salazar stated that there seems to be a lot that was pushed into the May Revision versus previous years. She added that the California Health and Human Services (CHHS) Secretary is convening work groups to discuss the proposed changes

to Medi-Cal and MRMIB staff should be included. Ms. Michel stated that she attended the meeting in Sacramento and will continue to participate. She added that the waiver concept paper should be done in May and work groups are currently being convened. She encouraged those that were interested to attend the Los Angeles conference call meeting and provided the number for the Panel to call in.

Dr. Beck stated that she was concerned that Medi-Cal eligibility was being aligned with Supplemental Security Income (SSI). She added that the proposed changes seemed to be about ramping down eligibility and focusing on the disabled.

Mr. Kozai asked if the Medi-Cal block waiver was different from the Federal block waiver and if there was a basis for the demonstration. Ms. Iseri responded that DHS would submit the waiver and articulate what they intended to demonstrate.

Quality Improvement Work Group Update

Lorraine Brown, Deputy Director of Benefits and Quality Monitoring for MRMIB, stated that the CCS Orthodontia discussion was removed from the Agenda because they are working on updating the report since it was last presented to the Panel. Ms. Brown stated that the report would be presented at the May 4, 2004 Advisory Panel meeting.

Ms. Brown provided background information for the establishment of the Quality Improvement Work Group and presented a summary of the recommendations made by the Work Group. The Panel requested that she continue to keep them informed of the activities of the Work Group.

Ms. Stanley-Salazar stated that she was pleased to see the addition of the mental health utilization and chemical dependency utilization measure. She asked for clarification on how these measures would be implemented in the contracts. Ms. Brown stated that the current contracts were extended and the chemical dependency utilization measure was put into the amendment. She added that the other new measures would be added when the contracts are reprocured. Ms. Stanley-Salazar stated that she would like to get more information on the chemical dependency utilization measure to pass on to the organizations with which she is affiliated.

Dr. Beck stated that she was concerned that Diabetes II was being used as a proxy for obesity, and suggested that in the first or second year, staff should look at whether the clinician has identified obesity or not. Ms. Brown responded that the Work Group struggled with that, but no one knew how to determine whether a physician was collecting Body Mass Index (BMI) without reviewing medical charts, which would be difficult administratively. She added that there is a diagnosis code for obesity, but there was concern among the Work Group that physicians may not use that code. Dr. Beck stated that the obesity code is underutilized, but physicians need to be sensitized to it. She added that in children, the medical team always uses the height and weight measure, which can be collected without going into the notes, and could be used to measure obesity. Ms. Brown responded that she would bring this information back to the Work Group.

Dr. Beck made a motion that obesity as a condition should be reviewed by the Work Group to identify appropriate codes using either height or weight measures on the chart or the obesity code. The motion was unanimously approved.

Mr. Diluigi asked if the National Committee for Quality Assurance (NCQA) accreditation is used as an incentive similar to the Community Provider Plan (CPP) designation. Ms. Iseri stated that the CPP process rewards plans for using safety net providers. She added that accreditation is a labor intensive and expensive process that may compete with the CPP objective in terms of cost. Mr. Diluigi stated that there needs to be something more substantive to give accreditation meaning. Ms. Iseri stated that the CPP process is a state process and is governed by regulations. Any changes to the CPP process would require a change in statute and regulation. She added that the Work Group is looking at other ways to reward plans for accreditation.

Mr. Kozai asked how many plans are currently NCQA certified. Ms. Brown stated that there are four plans that are currently NCQA certified. Mr. Kozai asked if this was required by Medi-Cal. Ms. Brown responded no, and that NCQA's accreditation requirements are beyond state requirements. To participate in HFP, plans are required to comply with the requirements of the Knox-Keene Act. NCQA accreditation would be serve as a type of Good Housekeeping seal. She added that some states use NCQA accreditation to meet compliance with state requirements, but she doesn't know of any that require it for participation in state programs.

Mr. Diluigi stated that he likes the idea of using incentives, but they have to be meaningful. Ms. Brown stated that the Work Group looked at giving a discount for selecting an accredited plan or other monetary incentive for the plans that achieve a higher standard, but it is difficult in the current financial climate.

Ms. Brown stated that there is one outstanding issue regarding how to measure access to interpreter services. She stated that the Work Group would appreciate any comments or suggestions from the Panel.

Mr. Kozai stated that the providers are over inundated with report cards and recommended that any changes add value to what exists instead of heading in a direction that has no benefit. He added that to effectively say that quality is important, there must be incentives, financial or in terms of access, and they must be aligned so that the plans and physicians have an incentive to get data from the repository. Consumers are demanding quality and those that provide it should be rewarded because there is a lot of time and effort that goes into it. He added that it is important to be mindful of the administrative costs as well. Ms. Brown stated that the Work Group doesn't want to reinvent the wheel. She added that most of the measures are already required for other reporting purposes.

SB2

Ms. Iseri reported that after SB2 was signed by the Governor, its opposers formulated a referendum to put on the March ballot to overturn SB2. The superior court in Sacramento ruled that the petition accompanying the referendum to overturn SB 2 was misleading and that the referendum could not go on the ballot. This decision was appealed and overturned, but it was too late to put the referendum on the March ballot. The referendum will now be on the November ballot. Ms. Iseri added that as long as there is a referendum, implementation of SB2 is suspended. The California HealthCare Foundation will be issuing a request for proposal (RFP) soliciting issue papers. The issue papers will address such topics as how to structure the pool, underwriting tactics and premium assistance. Ms. Iseri referred the Panel to the California HealthCare Foundation website for SB2 at www.chcf.org and the MRMIB website at www.mrmib.ca.gov for additional information.

Mr. Diluigi stated that MRMIB staff are overwhelmed with their current workload and asked how they would meet the 2006 deadline without additional staff. Ms. Michel added that staff did an analysis to see when they would have to start to be ready for the 2006 implementation and found that if they had started in November 2003, they would still be behind.

Mr. Campana stated that other organizations, such as the unions, will come forward with their recommendations, but it will still require a tremendous amount of work.

Enrollment, Disenrollment and Single Point of Entry Reports

Ms. Michel reviewed the Enrollment, Disenrollment and Single Point of Entry Summary. She apologized that the data was from November, but staff have been busy with the transition and haven't finished setting up the system. She stated that there are more applications coming in without assistance and most are coming in incomplete, so it takes longer to enroll these children. She added that MAXIMUS is making five phone calls instead of three, but the Certified Application Assistants (CAA) were the ones that used to help these families.

Ms. Bonser-Bishop stated that in her organization, they sent out letters with applications to 3,000 people and only 20 people were enrolled from their outreach efforts.

Ms. Stanley-Salazar expressed concern that the cap could be set at the current enrollment level and added that the next four months of enrollment would be critical. Ms. Michel agreed that retention and reaching those not enrolled would be critical in the next four months.

Dr. Beck stated that many of the applicants are applying because someone told them about the program. She asked if there was a way to find out who recommended the applicant so that organization or person could follow up with them. Ms. Michel responded that the applicant's information is confidential and could not be given out.

Ms. Jazo-Bajet asked if most people are still reachable when they are called. Ms. Michel responded that a high number of calls are to a disconnected number and some have no forwarding address.

Dr. Beck asked if there was a way for voluntary assistants to get information. Ms. Michel stated that there is a toll free number for CAA's to get assistance from MAXIMUS and provided the number to the Panel. She added that she would also post this number on the MRMIB website.

Ms. Jazo-Bajet asked if there were more errors on the applications received by mail versus those received through health-e-app. Ms. Michel stated that there is not a large enough volume of applications from health-e-app to do an analysis, but the applications received by fax can also be incomplete.

Mr. Kozai asked who was looking at this at a macro level and stated that someone needed to look at what it was going to cost. He added that if CAA's were the biggest bang for the buck, a piece of the revenue to plans or providers should be used to bridge the gap. Ms. Michel responded that the Board has asked plans to take on a role in outreach. Currently, Blue Cross and Inland Empire are very active and more plans are asking to be involved because enrollment is down. Ms. Stanley-Salazar stated that the macro questions are asked when the legislative analysts ask or the legislature asks DHS. She added that DOF is supposed to be looking at this, but the Panel should bring these questions to the associations they belong to so that they can also start asking these questions. Mr. Diluigi stated that many organizations are doing self-funded application assistance but he is concerned that a cap on enrollment will put a damper on these efforts.

Ms. Michel stated that she would have current enrollment and disenrollment data at the March meeting and in the future, this data would be updated on the fifteenth of each month.

Administrative Vendor Transition

Ms. Michel reported on the status of the administrative vendor transition. She stated that everything has been transferred over to MAXIMUS. All of the data was converted by January 5, 2004 and the telephone lines were up on January 2, 2004. She added that there is currently a backlog of applications, but she is anticipating only minor problems by the end of February.

Juan Gallardo with Molina asked what the turn around time was for processing applications. Ms. Michel responded that the turn around time is four days and seven days for a complete or incomplete determination.

Elena Chavez with Consumers Union stated that the counties don't understand that this is a statewide cap and think it is by county. Ms. Michel stated that the cap will be first come, first serve. Ms. Chavez asked if there is a correlation between utilization and disenrollment. Ms. Michel stated when subscribers are asked if they used the services

while enrolled, many say no because they think they will be charged. The question has been reworded and this information will be available up to December.

Mr. Campana asked the Panel if there was something specific the Panel would like MRMIB staff to take to the Board or if the Panel should send a letter. Dr. Beck suggested that the Panel approve a motion to create a letter identifying the health dangers and financial shortfalls of the enrollment cap. The Panel discussed the issues that should be addressed in the letter. Dr. Beck made a motion that the Panel write a letter to the Board and other state agencies condemning the cap on HFP enrollment and the destruction of the safety net. The letter will also address the following items: the danger to children's health, the gap between HFP and Medi-Cal at age 6, negative business and financial implications and the general political loss of face. The letter will be drafted by a sub-committee and submitted by e-mail to all Panel members for final approval. The motion was unanimously approved. Ms. Bonser-Bishop, Dr. Beck and Mr. Kozai volunteered to assist in putting the letter together. Dr. Beck asked the Panel members to send her an e-mail with the items they wanted included in the letter. Laura Gutierrez stated that she would e-mail a new contact list to all Panel members by Wednesday, February 4, 2004.

Future Meeting Dates

Mr. Campana announced the following future meeting dates:

May 4, 2004 in Sacramento
August 3, 2004 in Sacramento
November 2, 2004 in Sacramento